Section 2: Recipient Eligibility

Eligibility Determination

For most recipients, Medicaid eligibility is determined by the local DSS in the county in which the individual resides. Applicants may enroll in person or by mail. Applicants for Medicaid are evaluated on income level, available financial resources, and criteria related to categorical standards such as age and disability. Families receiving Work First Family Assistance and individuals receiving Special Assistance benefits also receive Medicaid.

If a household's income exceeds the allowable level, the applicant may be eligible for Medicaid after sufficient medical expenses are incurred to meet a deductible. The deductible is calculated using a formula set by law.

Aged, blind, and disabled individuals (including children) who receive Supplemental Security Income (SSI) are automatically entitled to N.C. Medicaid benefits and are not required to make a separate Medicaid application at the county DSS office. SSI eligibility is determined by the Social Security Administration. If an SSI recipient needs Medicaid coverage prior to the effective date of the SSI coverage, the recipient may apply for this coverage at the county DSS office. The recipient must apply for retroactive SSI Medicaid within 60 days (90 days with good cause) of the date of the SSI Medicaid approval or denial notice in order to protect the SSI retroactive period.

Eligibility Categories

N.C. Medicaid recipients receive benefits in the following assistance categories:

- Medicaid—Work First Family Assistance (AAF)
- Medicaid—Aid to the Aged (MAA)
- Medicaid—Aid to the Blind (MAB)
- Medicaid—Aid to the Disabled (MAD)
- Medicaid—Families and Children (MAF)
- Medicaid—Families and Children, Family Planning Waiver (MAF-D)
- Medicaid—Families and Children, Breast and Cervical Cancer (MAF-W)
- Medicaid—Infants and Children (MIC)
- Medicaid—Pregnant Women (MPW)
- Medicaid—Special Assistance to the Blind (MSB)
- Foster Care; Adoption Subsidy (HSF; IAS)
- Special Assistance—Aid to the Aged (SAA)
- Special Assistance—Aid to the Disabled (SAD)
- Medicaid—Medicare-Qualified Beneficiaries (MQB)
- Medicaid—Refugees (MRF)
- Medicaid—Refugee Assistance (RRF)

Providers who have general eligibility questions should instruct their patients to contact their local DSS. For a list of all the local DSS offices, please refer to http://www.ncdhhs.gov/dss/local/.

When Does Eligibility Begin?

An individual is eligible for Medicaid the **month** in which categorical and other required conditions of eligibility are met. If all requirements are met during the month of application, eligibility begins the first day of that month.

If the individual has a deductible or excess resource and all other conditions are met, eligibility begins on the day of the month on which the deductible is met or the resource is reduced to the allowable limit. The Medicaid deductible is met when the individual or other budget unit member incurs eligible medical expenses that the budget unit member is responsible for paying from personal funds. Eligible medical expenses may be from the prior 24 months, or older if they meet the requirements. Current medical expenses are also used to meet the deductible. Certain inpatient hospital stays meet the deductible.

Eligibility for qualified alien residents who have been in the United States for fewer than five years and non-qualified alien residents is approved for emergency services only and is limited to only the services required to treat the emergency condition. To be eligible for emergency services, the individual must still meet all other eligibility requirements such as income, resources, age, and/or disability criteria, and categorical criteria such as being a caregiver to child under age 19.

Eligibility for most recipients ends on the last day of the month. Exceptions to this are a presumptively eligible pregnant woman whom the county DSS has determined to be ineligible and a qualified or non-qualified alien eligible to receive emergency services only.

Retroactive Eligibility

Retroactive coverage may be approved for up to three calendar months prior to the month of the application if the applicant meets all eligibility conditions in the retroactive period. Medicaid will pay for covered services received during the retroactive period provided that all other Medicaid guidelines are met. Providers may choose to accept or decline retroactive eligibility. However, the provider's office policy should be consistently enforced. If a provider accepts retroactive eligibility, upon receipt of Medicaid reimbursement, the provider shall refund to the recipient all money paid by the recipient for services covered by Medicaid.

Eligibility Reversals

In some cases an application for Medicaid benefits is initially denied and then later approved due to a reversal of a disability denial, a state appeal, or a court decision. Because some of these appeals and reversals are not final for many months, the county DSS can request an override of the claims filing time limit from DMA. Written notice is provided to the recipient and to the county DSS when the time limit override is approved. Recipients are instructed to immediately notify the provider of retroactive approval. Failure to do so will result in the recipient's being financially liable for the services provided. Refer to **Eligibility Denials** on page 2-14 for additional information.

Medicaid Identification Cards

Individuals approved for Medicaid receive a monthly Medicaid identification (MID) card as proof of their eligibility. (The exceptions are the MQB-B and MQB-E programs, from which recipients do not receive cards. See p. 2-10 for more information.) The MID card indicates eligibility and restrictions that apply to the recipient. It also shows information necessary for filing claims,

including the recipient's MID number, date of birth, insurance information, Medicaid managed care information, and recipient eligibility dates for which the card is valid.

A recipient's eligibility and managed care provider may change from month to month. Therefore, new MID cards are issued at the beginning of each month. The new card shows valid dates through the current calendar month. The "From" date may show eligibility for prior months in addition to the current calendar month.

Providers must request that recipients present their current MID card as proof of eligibility for the dates of services rendered. Recipients must present a valid MID card at each provider visit. Failure to provide proof of eligibility may result in the recipient's being financially liable for the service provided, as the provider can refuse to accept the recipient as a Medicaid client.

Blue and Pink Medicaid Identification Card Information

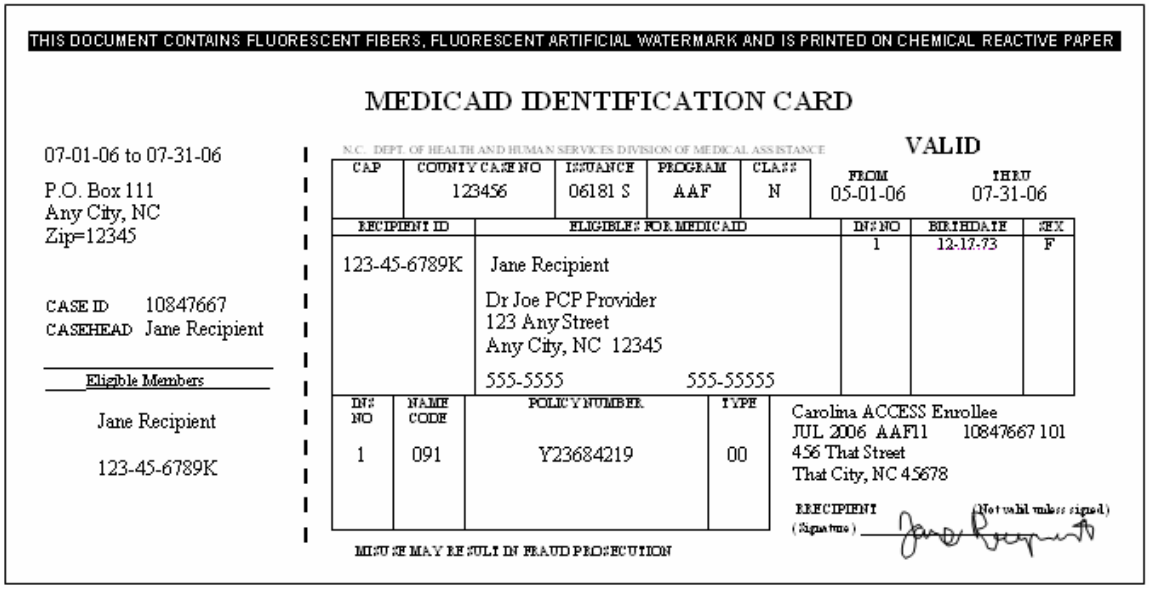
Field	Description
Insurance Number	A number in this field indicates that the recipient has specific third-party insurance.
Name Code	A 3-digit code identifies the name of the third-party insurance carrier. **Note:** The **Third-Party Insurance Code Book** is available on DMA's Web site at http://www.ncdhhs.gov/dma/tpr.html and provides a key to the insurance codes listed in this field.
Policy Number	Third-party insurance carrier's policy number, if applicable.
Type	A 2-digit code indicates the type of coverage provided in this policy. The coverage codes and types of coverage are listed below: 00—Major Medical Coverage 01—Basic Hospital with Surgical Coverage 02—Basic Hospital Coverage Only 03—Dental Coverage Only 04—Cancer Coverage Only 05—Accident Coverage Only 06—Indemnity Coverage Only 07—Nursing Home Coverage Only 08—Basic Medicare Supplement 10—Major Medical and Dental Coverage 11—Major Medical and Nursing Home Coverage 12—Intensive Care Coverage Only 13—Hospital Outpatient Coverage Only 14—Physician Coverage Only 15—Heart Attack Coverage Only 16—Prescription Drugs Coverage Only 17—Vision Care Coverage Only
Recipient Name and Address	The name and address of the head of the household is listed to the right of the insurance data.
Community Care of North Carolina, Carolina ACCESS Enrollees	If the recipient is enrolled with a CA (CCNC), the words "Carolina ACCESS Enrollee" appear above the recipient's name and address.
Date	The month and year for which the card was issued are listed here.
Signature	The recipient must sign the MID card where indicated.

Blue Medicaid Identification Card

The card lists the name of the casehead to the left and names of the eligible recipients in the middle of the card. Each eligible recipient has a specific recipient MID number. A recipient is eligible for Medicaid only if his or her name and MID number appear in the center of the card.

Carolina ACCESS (CA)/Community Care of North Carolina (CCNC) enrollees are identified by the phrase "Carolina ACCESS Enrollee" on the MID card. The name of the CA (CCNC) primary care provider (PCP), the PCP's address, and the daytime and after-hours telephone numbers for the practice are also listed on the card. The date listed under the phrase "Carolina ACCESS Enrollee" indicates that the recipient is enrolled with the PCP listed on the card for that month. Providers must contact the health plan listed on the recipient's MID card to obtain referral and authorization before providing treatment.

Refer to **Carolina ACCESS Referrals and Authorizations** on page 4-12 for additional information on managed care referrals.



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MEDICAID IDENTIFICATION CARD

07-01-06 to 07-31-06

P.O. Box 111
Any City, NC
Zip=12345

CASE ID 10847667
CASEHEAD Jane Recipient

Eligible Members

Jane Recipient

123-45-6789K

N.C. DEPT. OF HEALTH AND HUMAN SERVICES DIVISION OF MEDICAL ASSISTANCE

VALID

CAP	COUNTY CASE NO	ISSUANCE	PROGRAM	CLASS	FROM	THRU
	123456	06181 S	AAF	N	05-01-06	07-31-06

RECIPIENT ID	ELIGIBLE FOR MEDICAID	IN# NO	BIRTHDATE	SEX
123-45-6789K	Jane Recipient Dr Joe PCP Provider 123 Any Street Any City, NC 12345 555-5555 555-55555	1	12-17-73	F

IN# NO	NAME CODE	POLICY NUMBER	TYPE
1	091	Y23684219	00

Carolina ACCESS Enrollee
JUL 2006 AAF11 10847667 101
456 That Street
That City, NC 45678

RECIPIENT (Signature) (Not valid unless signed)

MISUSE MAY RESULT IN FRAUD PROSECUTION

Family Planning Waiver Card

Effective October 1, 2005, the Medicaid Family Planning Waiver (also known as the "Be Smart" program) was implemented. The waiver is designed to reduce unintended pregnancies and improve the well-being of children and families in North Carolina by extending eligibility for family planning services to eligible women ages 19 through 55 and men ages 19 through 60 whose income is at or below 185% of the federal poverty level.

The "Be Smart" Family Planning Waiver provides for **one** family planning annual exam and **six** follow-up family planning exams per 365 days. The waiver also provides birth control for eligible recipients.

Family planning services include

- Annual physical exam (includes one Pap test, STD testing and treatment, HIV testing)
- Follow-up family planning visits
- Pregnancy testing and counseling
- Referrals
- Birth control methods (Medicaid covered and FDA approved)

Birth control methods include

- Birth control pills
- Depo-Provera
- Contraceptive implants
- Diaphragm fitting
- Emergency contraception
- Intrauterine device (IUD)
- Natural family planning
- NuvaRing
- Ortho Evra
- Male and female sterilizations

The "Be Smart" Family Planning Waiver does not pay for the following services:

- Abortions
- Ambulance
- Dental
- Home health
- Infertility
- Inpatient hospital
- Optical
- Sick visits
- Treatment for cancer

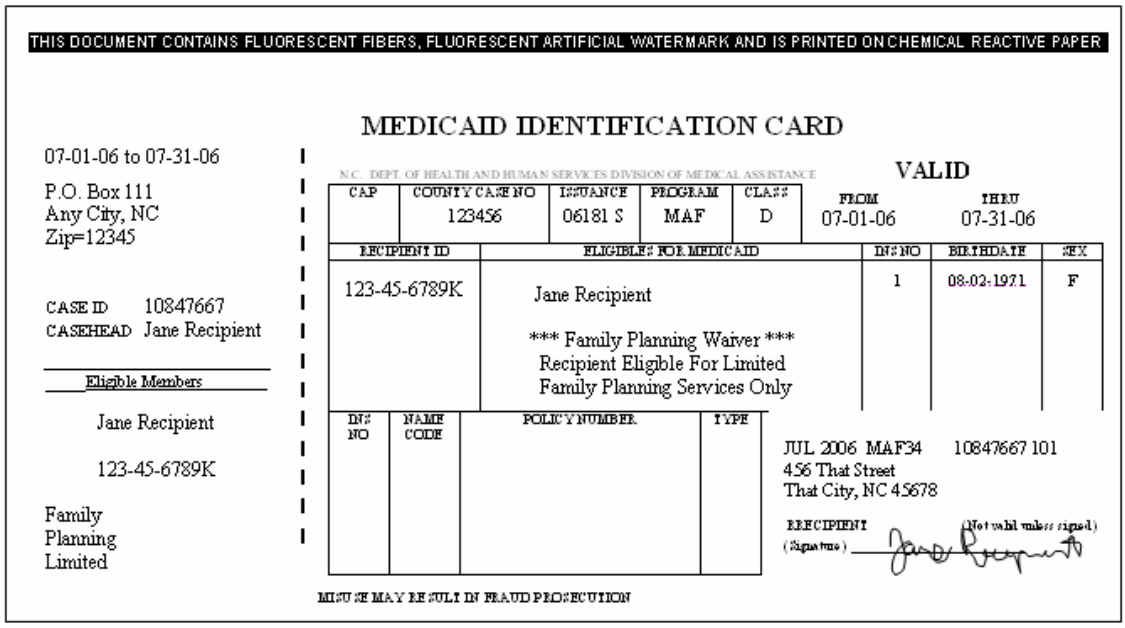
Problems or complications discovered during a family planning visit or caused by a family planning procedure are not covered by the "Be Smart" Family Planning Waiver. For services not covered, recipients should call the local DSS for a list of providers who offer affordable or free care.

For a complete list of services covered through the "Be Smart" Family Planning Waiver program, visit the program Web site, http://www.ncdhhs.gov/dma/MFPW/MFPW.htm.

There is no co-payment for Family Planning Waiver visits or prescriptions.

A new Medicaid eligibility category, MAF-D, has been created for the waiver. The eligible recipient will be identified by a blue Medicaid card bearing the statement, **"Family Planning Waiver: Recipient Eligible For Limited Family Planning Services Only."** The pharmacy stub has the phrase, **"Family Planning Limited."**

Only one name will be listed on the Medicaid card. Recipients are not required to enroll in Carolina ACCESS.



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MEDICAID IDENTIFICATION CARD

07-01-06 to 07-31-06

P.O. Box 111
Any City, NC
Zip=12345

CASE ID 10847667
CASEHEAD Jane Recipient

Eligible Members

Jane Recipient

123-45-6789K

Family Planning Limited

N.C. DEPT. OF HEALTH AND HUMAN SERVICES DIVISION OF MEDICAL ASSISTANCE

VALID

CAP	COUNTY CASE NO	ISSUANCE	PROGRAM	CLASS	FROM	THRU
	123456	06181 S	MAF	D	07-01-06	07-31-06

RECIPIENT ID	ELIGIBLE FOR MEDICAID	IN# NO	BIRTHDATE	SEX
123-45-6789K	Jane Recipient *** Family Planning Waiver *** Recipient Eligible For Limited Family Planning Services Only	1	08-02-1971	F

IN# NO	NAME CODE	POLICY NUMBER	TYPE

JUL 2006 MAF34 10847667 101
456 That Street
That City, NC 45678

RECIPIENT (Signature) (Not valid unless signed)

MISUSE MAY RESULT IN FRAUD PROSECUTION

Piedmont Cardinal Health Plan Card

Effective April 1, 2005, Piedmont Behavioral Healthcare began operating under a managed care waiver that applies to Medicaid recipients whose county of residence is Rowan, Stanly, Union, Davidson, or Cabarrus. The new managed care plan is known as Piedmont Cardinal Health Plan (PCHP). All Medicaid mental health, developmental disabilities, and substance abuse (MH/DD/SA) services for individuals receiving Medicaid from one of the five counties listed above are provided through PCHP. This includes services in the Innovations waiver, which replaces CAP/MR-DD in the five-county Piedmont area.

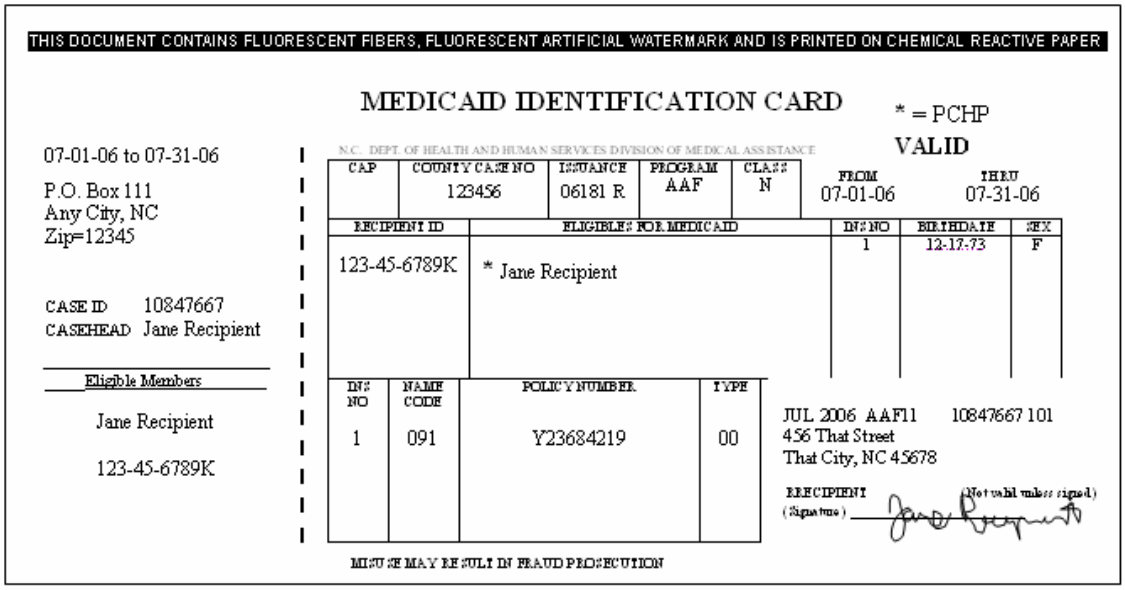
DMA pays PCHP a flat, per-member-per-month payment and PCHP in turn arranges and pays for MH/DD/SA services for recipients in the catchment area. DMA does not authorize, prior approve, or reimburse individual providers for these services.

All Medicaid recipients in the catchment area are covered by PCHP with the exception of the following groups:

- Medicare Qualified Beneficiaries
- Children under 3 years old, unless they are part of Innovations
- North Carolina Health Choice recipients
- MAF-D recipients

If the recipient is enrolled in the PCHP, the letters "PCHP" are printed on the card. If the recipient is enrolled in the Innovations plan, both "PCHP" and "CM" or simply "CM" is printed on the card. All behavioral health services for recipients participating in PCHP or CM or both must be approved by PCHP in order for the provider to be reimbursed.

Providers who are interested in applying to participate in the PCHP network should call Piedmont Provider Relations at 1-800-958-5596.



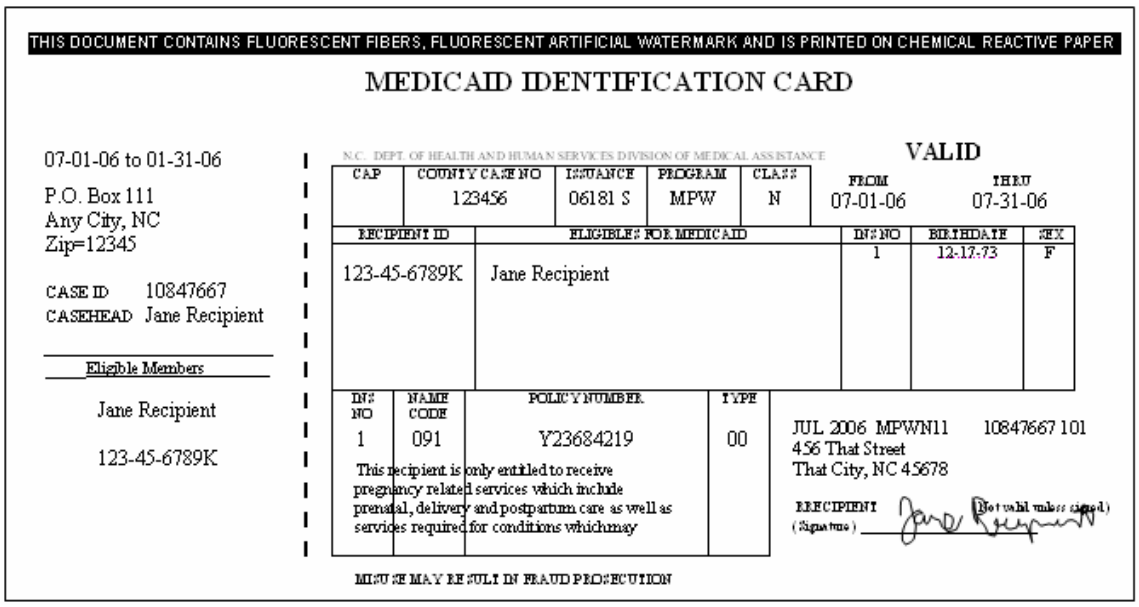
Pink Medicaid Identification Card

The pink MID card indicates that the recipient is eligible for pregnancy-related services only. Only the name of the eligible pregnant woman is listed on the card. No other recipients are listed on the card. A message is printed on the card stating that eligibility is limited to services relating to pregnancy and conditions that may complicate the pregnancy. If a second message appears on the MID card stating the recipient is presumptively eligible only, coverage is limited to ambulatory care.

CA (CCNC) enrollees are identified by the phrase "Carolina ACCESS Enrollee" on the MID card. The name of the CA (CCNC) PCP, the PCP's address, and the daytime and after-hours telephone numbers for the practice are also listed on the card. The date listed under the phrase "Carolina ACCESS Enrollee" indicates that the recipient is enrolled with the PCP listed on the card for that month. Providers must contact the PCP listed on the recipient's MID card to obtain referral and authorization before providing treatment.

Refer to **Carolina ACCESS Referrals and Authorizations** on page 4-12 for additional information on managed care referrals.

If the recipient is enrolled in the PCHP, the letters "PCHP" are printed on the card. If the recipient is enrolled in the Innovations plan, both "PCHP" and "CM" or simply "CM" is printed on the card. All behavioral health services for recipients participating in PCHP or CM or both must be approved by PCHP in order for the provider to be reimbursed.



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MEDICAID IDENTIFICATION CARD

07-01-06 to 01-31-06

P.O. Box 111
Any City, NC
Zip=12345

CASE ID 10847667
CASEHEAD Jane Recipient

Eligible Members

Jane Recipient

123-45-6789K

N.C. DEPT. OF HEALTH AND HUMAN SERVICES DIVISION OF MEDICAL ASSISTANCE

VALID

CAP	COUNTY CASE NO	ISSUANCE	PROGRAM	CLASS	FROM	THRU
	123456	06181 S	MPW	N	07-01-06	07-31-06

RECIPIENT ID	ELIGIBLE FOR MEDICAID	IN# NO	BIRTHDATE	SEX
123-45-6789K	Jane Recipient	1	12-17-73	F

IN# NO	NAME CODE	POLICY NUMBER	TYPE
1	091	Y23684219	00

This recipient is only entitled to receive pregnancy related services which include prenatal, delivery and postpartum care as well as services required for conditions whichmay

JUL 2006 MPWN11 10847667 101
456 That Street
That City, NC 45678

RECIPIENT (Signature) (Not valid unless signed.)

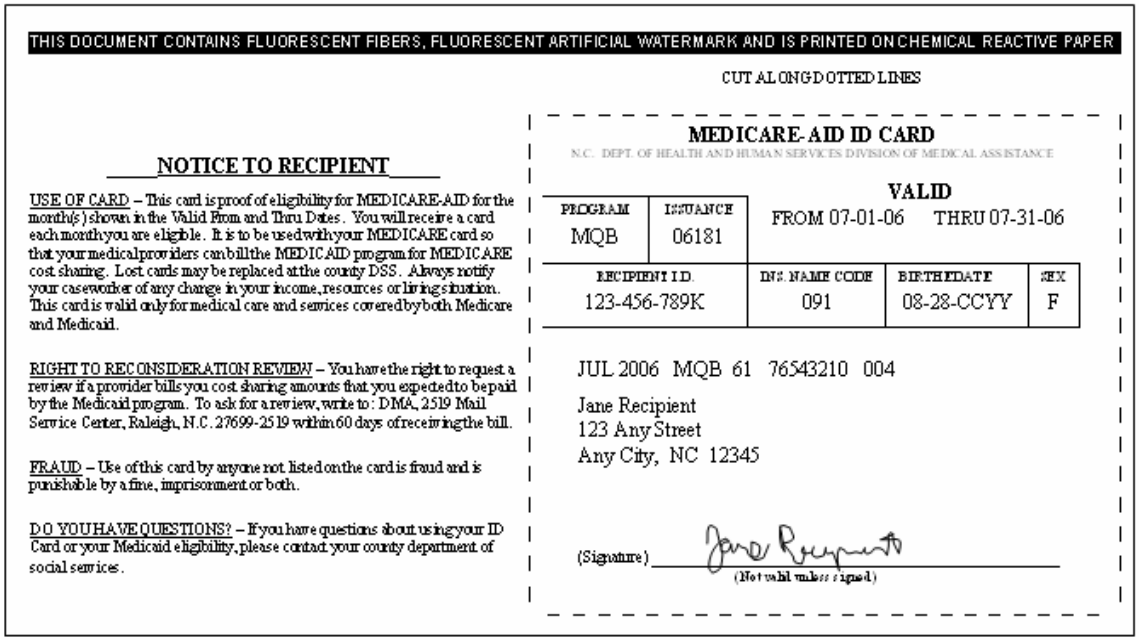
MISUSE MAY RESULT IN FRAUD PROSECUTION

Buff MEDICARE-AID ID Card

The buff-colored MEDICARE-AID ID card, referred to as the Medicare Qualified Beneficiary (MQB-Q) card, indicates that the recipient is eligible for the MEDICARE-AID Program. If both Medicare and Medicaid allow the service, Medicaid will pay the lesser of 1) the Medicare cost-sharing amount or 2) the Medicaid maximum allowable for the service less the Medicare payment. Recipients with a buff MEDICARE-AID ID card are not eligible to enroll in CCNC/CA.

Buff MEDICARE-AID ID Card Information

Field	Description
Program	The 3-character code indicates the recipient's coverage category.
Issuance	The 5-digit Julian date and letter (R or S) shows the date the card was prepared and mailed.
Valid From—Thru	The From and Thru dates indicate the eligibility period. The From date may show eligibility for prior months in addition to the current calendar month. The Thru date is the last day of the eligibility in the current month.
Recipient ID	This refers to the unique MID number assigned to the recipient. The MID number is a 9-digit number followed by an alpha character.
Insurance Name Code	A 3-digit code identifies the name of the third-party insurance carrier. **Note**: The **Third-Party Insurance Code** book is available on DMA's Web site at http://www.ncdhhs.gov/dma/tpr.html and provides a key to the insurance codes listed in this field.
Birth Date	The recipient's date of birth is listed by month, day, and year.
Sex	The recipient's sex is listed in this field.
County Number	A 2-digit code indicates the county that issued the card.
Case Identification Number	An 8-digit number is assigned to the head of household. (Refer to this number when requesting assistance from the recipient's county DSS office.)
County District Number	A 3-digit number indicates the district. This information is used only by the county.
Recipient Name and Address	The name and address of the recipient is listed in this area.
Signature	The recipient must sign the MID card where indicated.



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CUT ALONG DOTTED LINES

NOTICE TO RECIPIENT

USE OF CARD – This card is proof of eligibility for MEDICARE-AID for the month(s) shown in the Valid From and Thru Dates. You will receive a card each month you are eligible. It is to be used with your MEDICARE card so that your medical providers can bill the MEDICAID program for MEDICARE cost sharing. Lost cards may be replaced at the county DSS. Always notify your caseworker of any change in your income, resources or living situation. This card is valid only for medical care and services covered by both Medicare and Medicaid.

RIGHT TO RECONSIDERATION REVIEW – You have the right to request a review if a provider bills you cost sharing amounts that you expected to be paid by the Medicaid program. To ask for a review, write to: DMA, 2519 Mail Service Center, Raleigh, N.C. 27699-2519 within 60 days of receiving the bill.

FRAUD – Use of this card by anyone not listed on the card is fraud and is punishable by a fine, imprisonment or both.

DO YOU HAVE QUESTIONS? – If you have questions about using your ID Card or your Medicaid eligibility, please contact your county department of social services.

MEDICARE-AID ID CARD

N.C. DEPT. OF HEALTH AND HUMAN SERVICES DIVISION OF MEDICAL ASSISTANCE

PROGRAM	ISSUANCE	VALID
MQB	06181	FROM 07-01-06 THRU 07-31-06

RECIPIENT I.D.	DN# NAME CODE	BIRTHDATE	SEX
123-456-789K	091	08-28-CCYY	F

JUL 2006 MQB 61 76543210 004

Jane Recipient
123 Any Street
Any City, NC 12345

(Signature) Jane Recipient
(Not valid unless signed)

NOTICE TO PROVIDERS

ENROLLMENT – To receive payment you must be enrolled with Medicare and North Carolina Medicaid. If not enrolled, call DMA Provider Services at 919-855-4050 for information and forms.

BENEFITS – Medicaid coverage for the recipient of this card is limited to Medicare cost sharing for Medicare and Medicaid covered services. If your services are not billable to Medicare, you cannot bill the Medicaid Program for services for this recipient.

USE OF CARD – Use this card with the recipient's MEDICARE card as proof of eligibility for MEDICARE-AID benefits.

BILLING – Bill all claims to the Medicare carrier. Once Medicare payment has been received, file a Medicaid claim. Show Medicare payment, plus any penalties or outpatient psychiatric reductions, if applicable, as a third party payment on the claim form.

There are two other MQB classes that do not receive a Medicaid card, MQB-B and MQB-E. The benefits for the recipient are the payment of the Part B Medicare premium and automatic eligibility for the Low Income subsidy payment for the Part D prescription drug plan.

County-Issued Medicaid Identification Cards

The county DSS office has the authority to issue MID cards to recipients in an emergency (when the original card is incorrect or has been lost or destroyed), for newly approved applicants, or for retroactive eligibility dates. County-issued MID cards are identified by the word "EMERGENCY" stamped on the top margin of the MID card.

Verifying Eligibility

A recipient's eligibility status may change from month to month if financial and household circumstances change. For this reason, providers may request that Medicaid recipients provide proof of eligibility each time a service is rendered. A MID card with valid From and Thru dates covering the date(s) of service is proof of eligibility.

If a recipient no longer meets eligibility requirements, a written notice is mailed to the recipient at least 10 working days before the eligibility period ends. Should a recipient state that the MID card has not been received by mail, the provider should ask if a notice regarding a change in his eligibility status has been received. If the recipient has received a status change notice, the provider should inquire as to the nature of the change.

Recipients requesting services without proof of insurance or Medicaid coverage can be asked to pay for the services received. However, since individuals and families who are Medicaid-eligible have incomes ranging from as low as 30% of the federal poverty level up to 225% of the federal poverty level, most do not have the financial means to pay for care. Therefore, DMA provides additional methods for recipient eligibility verification.

Verification Methods

Although the recipient's MID card is the most expedient method for eligibility verification, eligibility can also be verified using the following methods:

Automated Voice Response System—Medicaid eligibility can be verified using the Automated Voice Response (AVR) system. Eligibility verification is available for services provided on the date of the inquiry as well as for services provided within the past 12 months. Refer to **Appendix A** for information on using the AVR system.

Electronic Data Interchange—Interactive eligibility verification programs are available from approved electronic data interchange (EDI) vendors. These vendors interface directly with the Medicaid recipient database maintained by EDS. Refer to **Interactive Recipient Eligibility Verification** on page 10-3 for additional information.

DMA Claims Analysis—To verify eligibility for dates of service over 12 months old, contact DMA Claims Analysis at 919-855-4045.

Transfer of Assets

Medicaid reimbursement for certain services provided in the recipient's home may be affected by a transfer of assets policy similar to the one that is currently in place for Medicaid recipients receiving care through nursing facilities and intermediate care facilities for the mentally retarded (ICF-MR), as well as for those recipients participating in the Community Alternatives Programs (CAP).

Services Included in the Policy

The Medicaid services affected by the policy are

- Durable medical equipment (DME), including the supplies provided by DME providers
- Supplies that are on the home health fee schedule and provided by private duty nursing (PDN) providers to PDN patients (the nursing care is not included in this policy)
- Home health services, including the supplies provided by home health agencies
- Home infusion therapy
- Personal care services in private residences (PCS and PCS–Plus)

Medicaid Recipients Subject to the Policy

The transfer of assets policy applies to individuals in the following Medicaid eligibility categories:

- Medicaid—Aid to the Aged (MAA)
- Medicaid—Aid to the Disabled (MAD)
- Medicaid—Aid to the Blind (MAB)
- Medicare Qualified Beneficiary (MQB-Q)

Adult care home providers should note that this policy does not apply to their residents receiving state or county Special Assistance. It does apply to a private pay adult care home resident if the individual is in one of the four eligibility categories (MAA, MAD, MAB, or MQB-Q).

Transfer of Assets Determination

When made aware that a recipient is seeking one of the specified home care services, the county DSS will make a transfer of assets determination. The resulting determination applies to any of the specified services; a separate determination for each service is not required. The determination may result in a sanction period if the recipient has transferred assets within the time frame specified by Medicaid eligibility guidelines. Refer to the *Adult Medicaid Manual,* Section MA-2240, Transfer of Resources, on the DMA Web site under County Links. The recipient is not eligible for Medicaid reimbursement of specified home care services during a sanction penalty period.

Provider Access to Transfer of Assets Information

Providers may access the AVR system to get a recipient's transfer of assets status as of a specified date. Refer to **Section 2, Verifying Eligibility,** in this billing guide. Providers will receive one of the following AVR system responses:

- The recipient has not been assessed. The provider should ask the recipient to contact the county DSS to begin a transfer of assets assessment.

- The recipient is in a penalty period for the given date of service and claims for the specified services will be denied.
- The recipient is not in a penalty period for the given date of service.

The AVR system provides information that is in the claims processing system at the time of the inquiry. Because a penalty period can be applied retroactively, transfer of assets information for a given date may change after the provider obtains the information.

Eligibility Denials

If claims are denied for eligibility reasons, the following steps should help resolve the denial and obtain reimbursement for covered dates of service for eligible recipients.

Step 1—Check for Errors on the Claim

Compare the recipient's MID card to the information entered on the claim.

If the information on the claim and the MID card do not match, correct the claim and resubmit on paper or electronically as a new day claim.

- If the claim is over the 365-day claim filing time limit, request a time limit override by submitting the claim and a completed Medicaid Resolution Inquiry form (**Appendix G-29** or www.ncdhhs.gov/dma/forms/mri.pdf). Include a copy of the remittance advice (RA) or other documentation of timely filing.
- If the claim was originally received and processed within the 365-day claim filing time limit, resubmit the claim on paper or electronically as a new day claim, ensuring that the recipient's MID number, provider number, "from" date of service, and total billed match the original claim exactly.

Step 2—Check for Data Entry Errors

Compare the RA to the information entered on the claim.

If the RA indicates that the recipient's name, MID number, or date of service has been keyed incorrectly, correct the claim and resubmit on paper or electronically as a new day claim.

- If the claim is over the 365-day claim filing time limit, follow the instructions in Step 1 for requesting a time limit override.
- If the claim was originally received and processed within the 365-day claim filing time limit, follow the instructions in Step 1 for resubmitting the claim.

Step 3—When All Information Matches

Verify that the recipient's eligibility information has been updated in the state eligibility file by calling the AVR system.

If the AVR system indicates that the recipient is ineligible, submit a Medicaid Resolution Inquiry form to DMA Claims Analysis. Include a copy of the recipient's MID card, the claim, and the RA. Mail to

DMA

Claims Analysis

2501 Mail Service Center

Raleigh NC 27699-2501

The Claims Analysis unit will review and update the information in EIS and resubmit the claim.

Do not mail eligibility denials to EDS, as this will delay the processing of your claim.

Refer to **Section 8, Resolving Denied Claims,** for additional information. Refer to **Appendix A** for information on using the AVR system.

Explanation of Benefits (EOBs) for Eligibility Denials

Article I. EOB	Message	Explanation
10	Diagnosis or service invalid for recipient's age.	Verify the recipient's MID number, the date of birth, diagnosis, and procedure codes. Make corrections, if necessary, and resubmit to EDS as a new claim. If all information is correct, send the claim and RA to DMA Claims Analysis.*
11	Recipient not eligible on service date.	Follow the instructions outlined in Steps 1, 2, and 3 above.
12	Diagnosis or service invalid for recipient sex.	Verify the recipient's MID number, the date of birth, diagnosis, and procedure codes. Make corrections, if necessary, and resubmit to EDS as a new claim. If all information is correct, send the claim and RA to DMA Claims Analysis.*
84	Recipient is partially ineligible for service dates. Resubmit a new claim billing for only eligible dates of service.	Verify eligibility and coverage dates using the AVR system. Resubmit the claim for eligible dates of service only.
93	Patient deceased per state eligibility file.	Verify the recipient's MID number and the date of service. Make corrections, if necessary, and resubmit to EDS as a new claim. If all information is correct, send the claim and RA to DMA Claims Analysis.*
120	Recipient MID number missing. Enter MID and submit as a new claim.	Verify the recipient's MID number and enter it in the correct block or form locator. Resubmit to EDS as a new claim.
139	Services limited to presumptive eligibility.	Verify from the recipient's MID card that on the date of service the recipient was eligible for all prenatal services, delivery, and postpartum care as well as for services required for conditions that may complicate the pregnancy on the date of service. If a second "presumptive eligibility" message does not appear on the MID card, send the claim and a copy of the RA to DMA Claims Analysis.*
143	MID number not on state eligibility file.	Follow instructions in Steps 1 and 2 above. Make corrections, if necessary, and resubmit to EDS as a new claim. If the MID card is not available, obtain the recipient's correct MID number through the AVR system by using the Social Security Number (SSN) and date of birth. If recipient's SSN is unknown, call DMA Claims Analysis* to obtain the correct MID number.

EOB table continues on next page

Article I. EOB	Message	Explanation
191	MID number does not match patient name.	Verify the recipient's name and MID number with the MID card. If all information is correct, the denial may have occurred because the recipient's name has been changed on Medicaid's records since the card was issued. Call EDS Provider Services to verify the patient's name. Correct and resubmit to EDS as a new claim.
292	Qualified Medicare Beneficiary—MQB recipient	If services billed are covered by Medicare, file charges to Medicare first. For dates of service prior to October 1, 2002, attach the Medicare voucher to the Medicaid claim. For dates of service between October 1, 2002 and September 5, 2004, enter the Medicare payment on the Medicaid claim. If services are not covered by Medicare, verify eligibility benefits using the AVR system to see if the recipient's eligibility has been changed to full benefits. If so, resubmit the claim to EDS. If the recipient's status is still MQB, no payment can be made by Medicaid for services not paid by Medicare. For dates of service on or after September 6, 2004, attach the Medicare voucher to the Medicaid claim. Professional charges will be reimbursed a specific percentage of the co-insurance and deductible in accordance with the Part B reimbursement schedule.

*Refer to **Appendix C** for appropriate phone numbers.

24-Visit Limitation

North Carolina law allows Medicaid recipients up to 24 ambulatory medical visits per fiscal year (July 1–June 30). These visits include visits to any one or a combination of the following: physicians' offices, outpatient clinics, optometrists, chiropractors, and podiatrists. The services listed below do not count toward the 24-visit limit.

1. Services provided to recipients under 21 years of age
2. Health Check examinations provided to recipients under 21 years of age
3. Home health services
4. Inpatient hospital services (inpatient physician services are not exempt from the 24 visits)
5. Emergency department services
6. Services provided to residents of nursing facilities or ICF-MRs
7. Prenatal and pregnancy-related services
8. Dental services
9. Mental health services subject to prior approval
10. Services for recipients enrolled in a CAP
11. Services covered by both Medicare and Medicaid

How to Request an Exemption

An exemption to the 24 ambulatory medical visit limitation must be requested by the provider who is most knowledgeable about the recipient's condition. An exemption may be approved when a recipient has any life-threatening illness or is in the terminal stage of any illness (as supported by the physician's documentation). Examples of life-threatening illnesses may include, but are not limited to, the following:

1. End-stage lung disease
2. End-stage renal disease
3. Chemotherapy and/or radiation therapy for malignancy
4. Acute sickle cell disease
5. Unstable disease (does not apply to diabetic recipients whose condition is controlled by oral medications, diet, or insulin)
6. Hemophilia or other blood clotting disorders

If the provider believes that the recipient meets the requirements for an exemption from the 24 ambulatory medical visit limit and has received a denial for visits billed, the provider may request an exemption. To request an exemption, the provider must submit the request in letter form, stating the recipient's name, MID number, and primary diagnosis. The Certificate of Medical Necessity form(s) with the appropriate ICD-9 codes and code V82.9 in block 21, along with medical documentation supporting the exemption, must also be included with the request. A prescription written by the physician is unacceptable documentation and will not be accepted. The letter and denied claim must be sent to

EDS—Medical Director
P.O. Box 300001
Raleigh NC 27622

The medical director reviews each request and responds in writing for denials of the requests for the exemption from the 24 ambulatory medical visit limitation.

Co-payments

The following co-payments apply to all Medicaid recipients except those specifically exempted by law from co-payment.

Service	Co-payment
Chiropractic	$2.00 per visit
Dental	$3.00 per visit
Prescription drugs and insulin—generic or brand name	$3.00 per prescription (with the exception of recipients enrolled in Medicare Part D)
Ophthalmologist	$3.00 per visit
Optical supplies and services	$2.00 per visit
Optometrist	$3.00 per visit
Outpatient	$3.00 per visit
Physician	$3.00 per visit
Podiatrist	$3.00 per visit

Providers may bill the patient for the applicable co-payment amount, but may not refuse services for inability to pay co-payment. **DO NOT ENTER CO-PAYMENT AS A PRIOR PAYMENT ON THE CLAIM FORM**. The co-payment is deducted automatically when the claim is processed.

Co-payment Exemptions

Providers may not charge co-payments for the following services:

- Ambulance services
- Dental services provided in a health department
- Diagnostic X-ray
- DME
- Family planning services
- Federally Qualified Health Center (FQHC) core services
- Health Check (EPSDT)–related services
- Hearing aid services
- HIV case management
- Home health services
- Home infusion therapy
- Hospice services
- Hospital emergency department services, including physician services delivered in the emergency department
- Hospital inpatient services (inpatient physician services **are not** exempt)
- Laboratory services performed in the hospital
- Mental health clinic services

- Non-hospital dialysis facility services
- PCS or PCS–Plus
- PDN services
- Rural Health Clinic (RHC) core services
- Services covered by **both** Medicare and Medicaid
- Services in state-owned psychiatric hospitals
- Services provided to CAP participants
- Services provided to residents of nursing facilities, ICF-MRs, and psychiatric hospitals
- Services related to pregnancy
- Services to individuals under the age of 21

EPSDT Policy Instructions Update

Background

Federal Medicaid law at 42 U.S.C.§ 1396d(r) [1905(r) of the Social Security Act] requires state Medicaid programs to provide early and periodic screening, diagnosis, and treatment (EPSDT) for recipients under 21 years of age. Within the scope of EPSDT benefits under the federal Medicaid law, states are required to cover any service that is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition identified by screening," whether or not the service is covered under the North Carolina State Medicaid Plan. The services covered under EPSDT are limited to those within the scope of the category of services listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]. The listing of EPSDT/Medicaid services is appended to this instruction.

EPSDT services include any medical or remedial care that is medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem]. This means that EPSDT covers most of the treatments a recipient under 21 years of age needs to stay as healthy as possible, and North Carolina Medicaid must provide for arranging for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment the need for which is disclosed by such child health screening services. **"Ameliorate"** means to improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Even if the service will not cure the recipient's condition, it must be covered if the service is medically necessary to improve or maintain the recipient's overall health.

EPSDT makes short-term and long-term services available to recipients under 21 years of age without many of the restrictions Medicaid imposes for services under a waiver **OR** for adults (recipients over 21 years of age). For example, a service must be covered under EPSDT if it is necessary for immediate relief (e.g., pain medication). It is also important to note that treatment need not ameliorate the recipient's condition taken as a whole, but need only be medically necessary to ameliorate one of the recipient's conditions. The services must be prescribed by the recipient's physician, therapist, or other licensed practitioner and often must be approved in advance by Medicaid. See the *Basic Medicaid Billing Guide*, **Sections 2 and 6,** on DMA's Web site for further information about EPSDT and prior approval requirements.

EPSDT Features

Under EPSDT, there is:

1. **No Waiting List for EPSDT Services**

   EPSDT does not mean or assure that physicians and other licensed practitioners or hospitals/clinics chosen by the recipient and/or his/her legal representative will not have waiting lists to schedule appointments or medical procedures. However, Medicaid cannot impose any waiting list and must provide coverage for corrective treatment for recipients under 21 years of age.

2. **No Monetary Cap on the Total Cost of EPSDT Services***

   A child under 21 years of age financially eligible for Medicaid is entitled to receive EPSDT services without any monetary cap provided the service meets all EPSDT criteria specified in this policy instruction. If enrolled in a Community Alternatives Program (CAP), the recipient under 21 years of age may receive **BOTH** waiver and EPSDT services. However, it is important to remember that the conditions set forth in the waiver concerning the recipient's budget and continued participation in the waiver apply. That is, the cost of the recipient's care must not exceed the waiver cost limits specified in the CAP waivers for Children (CAP/C) or Disabled Adults (CAP/DA). Should a recipient enrolled in the CAP waiver for Persons with Mental Retardation and Developmental Disabilities (CAP-MRDD) need to exceed the waiver cost limit, prior approval must be obtained from ValueOptions.

   ***EPSDT services are defined as Medicaid services within the scope of the category of services listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]. See attached listing.**

3. **No Upper Limit on the Number of Hours or Units under EPSDT**

   For clinical coverage policy limits to be exceeded, the provider's documentation must address why it is medically necessary to exceed the limits in order to correct or ameliorate a defect, physical or mental illness, or condition [health problem].

4. **No Limit on the Number of EPSDT Visits to a Physician, Therapist, Dentist, or Other Licensed Clinician**

   To exceed such limits, the provider's documentation must address why it is medically necessary to exceed the limits in order to correct or ameliorate a defect, physical or mental illness, or condition [health problem].

5. **No Set List that Specifies When or What EPSDT Services or Equipment May Be Covered**

   Only those services within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act] can be covered under EPSDT. See attached listing. However, specific limitations in service definitions, clinical policies, or DMA billing codes **MAY NOT APPLY** to requests for services for children under 21 years of age.

6. **No Co-payment or Other Cost to the Recipient**

7. **Coverage for Services That Are Never Covered for Recipients over 21 Years of Age**

Only those services within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act] can be covered under EPSDT. See attached listing. Provider documentation must address why the service is medically necessary to correct or ameliorate a defect, physical and mental illness, or condition [health problem].

8. Coverage for Services Not Listed in the N.C. State Medicaid Plan

Only those services within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act] can be covered under EPSDT. See attached listing.

EPSDT Criteria

It is important to note that the service can only be covered under EPSDT if all criteria specified below are met.

1. EPSDT services must be coverable services within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]. For example, "rehabilitative services" are a covered EPSDT service, even if the particular rehabilitative service requested is not listed in DMA clinical policies or service definitions.
2. The service must be medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] diagnosed by the recipient's physician, therapist, or other licensed practitioner. By requiring coverage of services needed to correct or ameliorate a defect, physical or mental illness, or a condition [health problem], EPSDT requires payment of services that are medically necessary to sustain or support rather than cure or eliminate health problems to the extent that the service is needed to correct or ameliorate a defect, physical or mental illness, or condition [health problem].
3. The requested service must be determined to be medical in nature.
4. The service must be safe.
5. The service must be effective.
6. The service must be generally recognized as an accepted method of medical practice or treatment.
7. The service must not be experimental/investigational.

Additionally, services can only be covered if they are provided by a North Carolina Medicaid enrolled provider for the specific service. For example, only a North Carolina Medicaid enrolled durable medical equipment (DME) provider may provide DME to a Medicaid recipient. This may include an out-of-state provider who is willing to enroll if an in-state provider is not available.

Important Points about EPSDT Coverage

General

1. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. EPSDT services must be coverable within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]. EPSDT requires Medicaid to cover these services if they are medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]. **"Ameliorate"** means to improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

3. Recipients under 21 must be afforded access to the full panoply of EPSDT services, including case management. Case management must be provided to a Medicaid eligible child if medically necessary to correct or ameliorate the child's condition regardless of eligibility for CAP waiver services.
4. EPSDT services need not be services that are covered under the North Carolina State Medicaid Plan or under any of the Division of Medical Assistance's (DMA) clinical coverage policies or service definitions or billing codes.
5. Under EPSDT, North Carolina Medicaid must make available a variety of individual and group providers qualified and willing to provide EPSDT services.
6. EPSDT operational principles include those specified below.

    a. When state staff or vendors review a covered state Medicaid plan services request for prior approval or continuing authorization (UR) for an individual under 21 years of age, the reviewer will apply the EPSDT criteria to the review. This means that:

        (1) Requests for EPSDT services do **NOT** have to be labeled as such. Any proper request for services for a recipient under 21 years of age is a request for EPSDT services. For recipients under 21 years of age enrolled in a CAP waiver, a request for services must be considered under EPSDT as well as under the waiver.

        (2) The decision to approve or deny the request will be based on the recipient's medical need for the service to correct or ameliorate a defect, physical [or] mental illness, or condition [health condition].

    b. The specific coverage criteria (e.g., particular diagnoses, signs, or symptoms) in the DMA clinical coverage policies or service definitions do NOT have to be met for recipients under 21 years if the service is medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problems].

    c. The specific numerical limits (number of hours, number of visits, or other limitations on scope, amount or frequency) in DMA clinical coverage policies, service definitions, or billing codes do NOT apply to recipients under 21 years of age if more hours or visits of the requested service are medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem]. This includes the hourly limits and location limits on Medicaid Personal Care Services (PCS) and Community Support Services (CSS).

    d. Other restrictions in the clinical coverage policies, such as the location of the service (e.g., PCS only in the home), prohibitions on multiple services on the same day or at the same time (e.g., day treatment and residential treatment) must also be waived under EPSDT as long as the services are medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem].

    Out-of-state services are NOT covered if similarly efficacious services that are medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problems] are available anywhere in the state of North Carolina. Services delivered without prior approval will be denied. There is no retroactive prior approval for services that require prior approval, unless there is retroactive Medicaid eligibility. See DMA's *Basic Medicaid Billing Guide,* **Section 6,** found on the Web site specified below for further information re the provision of out-of-state services: http://www.ncdhhs.gov/dma/medbillcaguide.htm

    e. Providers or family members may write directly to the Assistant Director for Clinical Policy and Programs, Division of Medical Assistance, requesting a review for a specific service. However, DMA vendors and contractors must consider any request for state Medicaid plan services for a recipient under 21 years of age under EPSDT

criteria when the request is made by the recipient's physician, therapist, or other licensed practitioner in accordance with the Division's published policies. If necessary, such requests will be forwarded to DMA or the appropriate vendor.

f. Requests for prior approval for services must be fully documented to show medical necessity. This requires current information from the recipient's physician, other licensed clinicians, the requesting qualified provider, and/or family members or legal representative. If this information is not provided, Medicaid or its vendor will have to obtain the needed information, and this will delay the prior approval decision. See procedure below for requesting EPSDT services for further detail about information to be submitted.

g. North Carolina Medicaid retains the authority to determine how an identified type of equipment, therapy, or service will be met, subject to compliance with federal law, including consideration of the opinion of the treating physician and sufficient access to alternative services. Services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner, the determination process does not delay the delivery of the needed service, and the determination does not limit the recipient's right to free choice of North Carolina Medicaid enrolled providers who provide the approved service. It is not sufficient to cover a standard, lower cost service instead of a requested specialized service if the lower cost service is not equally effective in that individual case.

h. Restrictions in CAP waivers such as no skilled nursing for the purpose of monitoring do not apply to EPSDT services if skilled monitoring is medically necessary. Nursing services will be provided in accordance with 21 NCAC 36.0221 (adopted by reference).

i. Durable medical equipment (DME), assistive technology, orthotics, and prosthetics do NOT have to be included on DMA's approved lists or be covered under a CAP waiver program in order to be covered under EPSDT subject to meeting the criteria specified in this policy.

j. Medicaid will cover treatment that the recipient under 21 years of age needs under this EPSDT policy. DMA will enroll providers, set reimbursement rates, set provider qualifications, and assure the means for claims processing when the service is not already established in the North Carolina State Medicaid Plan.

k. Requests for prior approval of services are to be decided with reasonable promptness, usually within 15 business days. No request for services for a recipient under 21 years of age will be denied, formally or informally, until it is evaluated under EPSDT.

l. If services are denied, reduced, or terminated, proper written notice with appeal rights must be provided to the recipient and copied to the provider. The notice must include reasons for the intended action, citation that supports the intended action, and notice of the right to appeal. Such a denial can be appealed in the same manner as any Medicaid service denial, reduction, or termination.

m. The recipient has the right to continued Medicaid payment for services currently provided pending an informal and/or formal appeal. This includes the right to reinstatement of services pending appeal if there was less than a 30 day interruption before submitting a re-authorization request.

EPSDT Coverage and CAP Waivers

1. Waiver services are available only to participants in the CAP waiver program and are not a part of the EPSDT benefit unless the waiver service is ALSO an EPSDT service (e.g. durable medical equipment).
2. Any request for services for a CAP recipient under age 21 must be evaluated under BOTH the waiver and EPSDT.
3. Additionally, a child financially eligible for Medicaid outside of the waiver is entitled to elect EPSDT services without any monetary cap instead of waiver services.
4. ANY child enrolled in a CAP program can receive BOTH waiver services and EPSDT services. However, if enrolled in CAP/C or CAP/DA, the cost of the recipient's care must not exceed the waiver cost limit. Should the recipient be enrolled in the Community Alternatives Program for Persons with Mental Retardation and Developmental Disabilities (CAP-MRDD), prior approval must be obtained to exceed the waiver cost limit.
5. A recipient under 21 years of age on a waiting list for CAP services, who is an authorized Medicaid recipient without regard to approval under a waiver, is eligible for necessary EPSDT services without any waiting list being imposed by Medicaid. For further information, see "No Waiting List for EPSDT" on page 2 of this instruction.
6. EPSDT services must be provided to recipients under 21 years of age in a CAP program under the same standards as other children receiving Medicaid services. For example, some CAP recipients under 21 years of age may need daily in- school assistance supervised by a licensed clinician through community intervention services (CIS) or personal care services (PCS). It is important to note that Medicaid services coverable under EPSDT may be provided in the school setting, including to CAP-MRDD recipients. Services provided in the school and covered by Medicaid must be included in the recipient's budget.
7. Case managers in the Community Alternatives Program for Disabled Adults (CAP/DA) can deny a request for CAP/DA waiver services. If a CAP/DA case manager denies, reduces, or terminates a CAP/DA waiver service, it is handled in accordance with DMA's recipient notices procedure.

   No other case manager can deny a service request supported by a licensed clinician, either formally or informally.

8. When a recipient under 21 years of age is receiving CAP services, case managers must request covered state Medicaid plan services as indicated below. Covered state Medicaid plan services are defined as requests for services, products, or procedures covered by the North Carolina State Medicaid Plan.

   a. **CAP/C:** Requests for medical, dental, and behavioral health services covered under the North Carolina State Medicaid Plan that require prior approval must be forwarded to the appropriate vendor and a plan of care revision submitted to the CAP/C consultant at DMA in accordance with the CAP/C policy. A plan of care revision for waiver services must be submitted to the CAP/C consultant as well.

   b. **CAP/DA:** Requests for medical, dental, and behavioral health services covered under the North Carolina State Medicaid Plan that require prior approval must be forwarded to the appropriate vendor and a plan of care revision submitted to the CAP/DA case manager in accordance with the CAP/DA policy. A plan of care revision for waiver services must be submitted to the CAP/DA case manager as well. **All EPSDT requests must be forwarded to the CAP/DA consultant at DMA.**

c. **CAP-MRDD:** All EPSDT and covered state Medicaid plan requests for behavioral health services must be forwarded to ValueOptions. This includes requests for children not in a waiver who have a case manager. Requests for medical and dental services covered under the North Carolina State Medicaid Plan must be forwarded to the appropriate vendor (medical or dental) for review and approval. Do **NOT** submit such requests to ValueOptions. Plan of care revisions must be submitted in accordance with the CAP-MRDD policy.

9. An appeal under CAP must also be considered under EPSDT criteria as well as under CAP provisions if the appeal is for a Medicaid recipient under 21 years of age.

EPSDT Coverage and Mental Health/Developmental Disability/Substance Abuse (MH/DD/SA) Services

1. Staff employed by local management entities (LMEs) CANNOT deny requests for services, formally or informally. Requests must be forwarded to ValueOptions or the other appropriate DMA vendor if supported by a licensed clinician.
2. LMEs may NOT use the Screening, Triage, and Referral (STR) process or DD eligibility process as a means of denying access to Medicaid services. Even if the LME STR screener does not believe the child needs enhanced services, the family must be referred to an appropriate Medicaid provider to perform a clinical evaluation of the child for any medically necessary service.
3. Requests for prior approval of MH/DD/SA services for recipients under 21 must be sent to ValueOptions. If the request needs to be reviewed by DMA clinical staff, ValueOptions will forward the request to the Assistant Director for Clinical Policy and Programs.
4. If a recipient under 21 years of age has a developmental disability diagnosis, this does not necessarily mean that the requested service is habilitative and may not be covered under EPSDT. The EPSDT criteria of whether the service is medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem] apply. Examples include dual diagnoses and behavioral disorders. All individual facts must be considered.
5. All EPSDT requirements (except for the procedure for obtaining services) fully apply to the Piedmont waiver.

Procedure for Requesting EPSDT Services

Covered State Medicaid Plan Services

Should the service, product, or procedure require prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval. **If prior approval is required** and if the recipient does not meet the clinical coverage criteria or needs to exceed clinical coverage policy limits, submit documentation with the prior approval request that shows how the service at the requested frequency and amount is medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem] to the appropriate vendor or DMA staff. When requesting prior approval for a covered service, refer to the Basic Medicaid Billing Guide, section 6. If the request for service needs to be reviewed by DMA clinical staff, the vendor will forward the request to the Assistant Director for Clinical Policy and Programs. Should further information be required, the provider will be contacted. See the section entitled “Provider Documentation” for information re documentation requirements.

In the event **prior approval is not required** for a service and the recipient needs to exceed the clinical coverage policy limitations, it is not necessary to obtain prior approval from a vendor or DMA staff. See the section entitled "Provider Documentation" for information re documentation requirements.

Non-Covered State Medicaid Plan Services

Requests for non-covered state Medicaid plan services are requests for services, products, or procedures that are not included at all in the North Carolina State Medicaid Plan **but coverable** under federal Medicaid law, 1905(r) of the Social Security Act for recipients under 21 years of age. See attached listing. **Medical and dental** service requests for non-covered state Medicaid plan services and requests for a review when there is no established review process for a requested service should be submitted to the Division of Medical Assistance, Assistant Director for Clinical Policy and Programs at the address or facsimile (fax) number specified on the form entitled "Non-Covered State Medicaid Plan Services Request Form for Recipients Under 21 Years of Age". Requests for non-covered state Medicaid plan **mental health services** should be submitted to ValueOptions. The "Non-Covered State Medicaid Plan Services Request Form for Recipients Under 21 Years of Age" is available on the DMA Web site at http://www.ncdhhs.gov/dma/forms.html. To decrease delays in reviewing non-covered state Medicaid plan requests, providers are asked to complete this form. A review of a request for a non-covered state Medicaid plan service includes a determination that **ALL** EPSDT criteria specified in this memorandum are met.

Children's Special Health Services (CSHS) will no longer grant prior approval for DME, orthotics and prosthetics, and home health supplies not listed on the DMA fee schedules for recipients under 21 years of age. Effective August 01, 2007, providers should submit requests for these services on the form entitled "Non-Covered State Medicaid Plan Services Request Form for Recipients Under 21 Years of Age" to the Assistant Director for Clinical Policy and Programs, Division of Medical Assistance at the address specified on the form.

CSHS is also transitioning to Medicaid the prior approval process for the services specified below for recipients under 21 years of age. However, providers should continue to submit prior approval requests to CSHS for these services until advised to do otherwise. Details will be published in upcoming Medicaid Bulletins.

- Pediatric Mobility Systems, including non-listed components
- Augmentative and Alternative Communication Devices
- Oral Nutrition
- Cochlear Implant (CI) External Replacement Parts and Repairs for
- Over-the-Counter Medications

Submit the requests for the services specified immediately above to

Children's Special Health Services (CSHS)
N.C. Division of Public Health
1904 Mail Service Center
Raleigh NC 27699-1904
Telephone: 919-855-3701
FAX: 919-715-3848

Please specify that the request is for a Medicaid recipient under 21 years of age so that CSHS will know that EPSDT applies. Medicaid due process procedures must be applied to the request.

Provider Documentation

Documentation for either covered or non-covered state Medicaid plan services should show how the service will correct or ameliorate a defect, physical or mental illness, or a condition [health problem]. This includes a discussion about how the service, product, or procedure will correct or ameliorate (improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems) as well as the effectiveness and safety of the service, product, or procedure. Should additional information be required, the provider will be contacted.

For Further Information about EPSDT

- Important additional information about EPSDT and prior approval is found in the *Basic Medicaid Billing Guide*, **Sections 2** and **6,** and on the DMA EPSDT provider page. The Web addresses are specified below.

Basic Medicaid Billing Guide: http://www.ncdhhs.gov/dma/medbillcaguide.htm

Health Check Billing Guide: http://www.ncdhhs.gov/dma/bulletin.htm

EPSDT Provider Page: http://www.ncdhhs.gov/dma/EPSDTprovider.htm

- DMA and its vendors will conduct trainings beginning fall 2007 for employees, agents, and providers on this instruction. Details will be published as soon as available.

Attachments

- Listing of Medicaid (EPSDT) Services Found in the Social Security Act at 1905(a) [42 U.S.C. § 1396d(a)]
- Non-Covered State Medicaid Plan Services Request Form

Listing of EPSDT Services Found at 42 U.S.C. § 1396d(a)
[1905(a) of the Social Security Act]

- Inpatient hospital services (other than services in an institution for mental disease)
- Outpatient hospital services
- Rural health clinic services (including home visits for homebound individuals)
- Federally-qualified health center services
- Other laboratory and X-ray services (in an office or similar facility)
- EPSDT *(Note: EPSDT* offers periodic screening services for recipients under age *21 and Medicaid covered services* necessary to correct or ameliorate a *diagnosed physical* or mental condition)
- Family planning services and supplies
- Physician services (in office, recipient's home, hospital, nursing facility, or elsewhere)
- Medical and surgical services furnished by a dentist
- Home health care services (nursing services; home health aides; medical supplies, equipment, and appliances suitable for use in the home; physical therapy, occupation therapy, speech pathology, audiology services provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services)
- Private duty nursing services
- Clinic services (including services outside of clinic for eligible homeless individuals)

- Dental services
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders
- Prescribed drugs
- Dentures
- Prosthetic devices
- Eyeglasses
- Services in an intermediate care facility for the mentally retarded
- Medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law, specified by the Secretary (also includes transportation by a provider to whom a direct vendor payment can appropriately be made)
- Other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level
- Inpatient psychiatric hospital services for individuals under age 21
- Services furnished by a midwife, which the nurse-midwife is legally authorized to perform under state law, without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider throughout the maternity cycle
- Hospice care
- Case-management services
- TB-related services
- Respiratory care services
- Services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner, which the practitioner is legally authorized to perform under state law
- Personal care services (in a home or other location) furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease
- Primary care case management services

Definitions of the above federal Medicaid services can be found in the Code of Federal Regulations 42 CFR 440.1-440.170 at http://www.access.gpo.gov/nara/cfr/waisidx_06/42cfr440_06.html.

North Carolina
Department of Health and Human Services
Division of Medical Assistance
2501 Mail Service Center - Raleigh, N.C. 27699-2501

Michael F. Easley, Governor
Carmen Hooker Odom, Secretary

Mark T. Benton, Director
William W. Lawrence, Jr., M.D., Senior Deputy Director

FORM AVAILABLE ON DMA WEB SITE AT http://www.ncdhhs.gov/dma/forms.html

NON-COVERED STATE MEDICAID PLAN SERVICES REQUEST FORM FOR RECIPIENTS *UNDER* 21 YEARS OF AGE

RECIPIENT INFORMATION: Must be completed by physician, licensed clinician, or provider.

NAME: _____
DATE OF BIRTH: ____/____/____ *(mm/dd/yyyy)* **MEDICAID NUMBER:** _____
ADDRESS: _____
_____

MEDICAL NECESSITY: ***ALL REQUESTED INFORMATION, includingCPT and HCPCS codes, if applicable, as well as provider information must be completed. Please submit medical records that support medical necessity.***

REQUESTOR NAME: _____
MEDICAID PROVIDER #: _____
ADDRESS: _____
_____
TELEPHONE #: (____)_____
FAX #: _____

PROVIDER NAME: _____
MEDICAID PROVIDER #: _____
ADDRESS: _____
_____
TELEPHONE #: (____)_____
FAX #: _____

IN WHAT CAPACITY HAVE YOU TREATED THE RECIPIENT (incl. length of time you have cared for recipient and nature of the care):
_____
_____

PAST HEALTH HISTORY (incl. chronic illness):
_____
_____

RECENT DIAGNOSIS(ES) RELATED TO THIS REQUEST (incl. onset, course of the disease, and recipient's current status):
_____
_____

TREATMENT RELATED TO DIAGNOSIS(ES) ABOVE (incl. previous and current treatment regimens, duration, treatment goals, and recipient response to treatment(s)): _____

_____

_____

1 of 3 **-OVER-**

NAME:	MID #:	DOB:

NAME OF REQUESTED PROCEDURE, PRODUCT, OR SERVICE. (if applicable, please include *CPT AND HCPCS codes*). PROVIDE DESCRIPTION RE HOW REQUEST WILL CORRECT OR AMELIORATE THE RECIPIENT'S DEFECT, PHYSICAL OR MENTAL ILLNESS OR CONDITION [THE PROBLEM]. THIS DESCRIPTION *MUST* INCLUDE A DETAILED DISCUSSION ABOUT HOW THE SERVICE, PRODUCT, OR PROCEDURE WILL IMPROVE OR MAINTAIN THE RECIPIENT'S HEALTH IN THE BEST CONDITION POSSIBLE, COMPENSATE FOR A HEALTH PROBLEM, PREVENT IT FROM WORSENING, OR PREVENT THE DEVELOPMENT OF ADDITIONAL HEALTH PROBLEMS.

_____
_____
_____
_____
_____
_____
_____
_____
_____

IS THIS REQUEST FOR EXPERIMENTAL/INVESTIGATIONAL TREATMENT:
___YES ___NO IF YES, PROVIDE NAME AND PROTOCOL #_____
_____

IS THE REQUESTED PRODUCT, SERVICE, OR PROCEDURE CONSIDERED TO BE SAFE:
___YES ___NO IF NO, PLEASE EXPLAIN._____
_____
_____
_____

IS THE REQUESTED PRODUCT, SERVICE OR PROCEDURE EFFECTIVE:__YES ___NO
IF NO, PLEASE EXPLAIN._____
_____
_____

ARE THERE ALTERNATIVE PRODUCTS, SERVICES, OR PROCEDURES THAT WOULD BE MORE COST EFFECTIVE BUT SIMILARLY EFFICIACIOUS TO THE SERVICE REQUESTED: ___YES ___NO IF YES, SPECIFY WHAT ALTERNATIVES ARE APPROPRIATE FOR THE RECIPIENT AND PROVIDE EVIDENCE BASE WITH THIS REQUEST, IF AVAILABLE._____
_____
_____
_____
_____

WHAT IS THE EXPECTED DURATION OF TREATMENT:
_____
_____

NAME:	**MID #:**	**DOB:**

OTHER ADDITIONAL INFORMATION:_____

_____
_____
_____
_____
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_____
_____
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_____
_____

_____ _____

REQUESTOR'S SIGNATURE AND CREDENTIALS **DATE**

INCLUDE EVIDENCE-BASED LITERATURE TO SUPPORT THIS REQUEST IF AVAILABLE.

MAIL OR FAX COMPLETED FORM TO:

Assistant Director
Clinical Policy and Programs
Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699-2501
FAX: 919-715-7679

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